City of Duluth

Physician's Report / Employee Work Status

Physician: Please ensure that the employee receives a copy of this form and/or that it is faxed to the City at 218-730-5906, and, if work-related injury, to their TPA, RTW at 952-893-3700.

Name:_____ Social Security #:_____
Last First Middle

Address:_____

Work Related ❑ Not Work Related ❑ Undetermined ❑

Dx:_____

Physical Therapy At:_____ Frequency:_____ Duration: _____

❑ Return to Work, Regular Duty: ___/___/____ (Date) MMI: ❑ Yes ❑ No ___/___/____ (Date) PPD:___%

❑Return to Work, Restricted Duty: ___/___/____ (Date) To: ___/___/____ (Date)

EMPLOYEE CAN:		**NEVER**	**OCCASIONALLY**	**FREQUENTLY**	**CONTINUOUSLY**
Lift/Carry:	0 to 10 lbs	❑	❑	❑	❑
	11 to 25 lbs	❑	❑	❑	❑
	26 to 35 lbs	❑	❑	❑	❑
	36 to 50 lbs	❑	❑	❑	❑
	51 to 75 lbs	❑	❑	❑	❑
	76 to 100 lbs	❑	❑	❑	❑
Reach above shoulder		❑	❑	❑	❑
Push/Pull		❑	❑	❑	❑
Squat/Kneel/Stoop		❑	❑	❑	❑
Bending		❑	❑	❑	❑
Can use L/R	Simple Grasping	❑	❑	❑	❑
Hand for:	Firm Grasping	❑	❑	❑	❑
	Fine Manipulation	❑	❑	❑	❑
	Torquing	❑	❑	❑	❑

Work Hours: ❑ Full Shift ❑ Partial Shift ❑ Restricted Hours Per Day

Number of Hours/Day: ____ Sitting ____ Standing ____ Walking

Modifications Apply To: ❑ Work ❑ Home ❑ Leisure

This patient's employer has a return-to-work program and is committed to providing work within any restrictions.

Unable to work from : ___/__/____ (Date) To: ___/___/____ (Date)

Additional Comments:_____

_____

Return to clinic on: ___/___/____ (Date)

Referral to:_____

Physician's Signature:_____ Date: ___/___/____

Printed Name:_____ Clinic:_____

Address:_____

Phone:_____ Fax:_____